TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
KINDRED HEALTHCARE

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1362-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JANUARY 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Kindred Hospital Fort Worth Southwest submits this letter in support of its position that the services provided were medically reasonable and necessary, thus granting retro-authorization in this case is warranted."

Amount in Dispute: $12,607.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It appears the hospital dropped the ball with respect to not preauthorizing the disputed dates. The preauthorization Rule, 134.600, is quite clear. No payment is due for the dates not preauthorized."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2013 through February 11, 2013	Long Term Acute Care Hospital Services	$12,607.32	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective July 1, 2012, requires preauthorization for inpatient hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Please note: TMI has no record of preauthorization for dates 2/10/13, 2/10/13, and 2/11/13.

Issues

Does a preauthorization issue exist in this dispute? Is the requestor entitled to reimbursement?

Findings

The disputed dates of service, February 10, 2013 through February 11, 2013, were denied reimbursement based upon a lack of preauthorization.

A review of the submitted documentation indicates that the claimant was hospitalized from February 4, 2013 to February 25, 2013.

28 Texas Administrative Code §134.600(p)(1) states, "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay.

On February 1, 2013, the respondent gave preauthorization for a seven (7) day inpatient long term acute care hospital stay between February 2, 2013 and February 9, 2013.

28 Texas Administrative Code §134.600(q) states, "The health care requiring concurrent review for an extension for previously approved services includes: (1) inpatient length of stay."

On February 13, 2013, concurrent preauthorization approval was obtained for twelve (12) days of long term acute care for wound care between February 13, 2013 and February 25, 2013.

The requestor states, "services provided were medically reasonable and necessary, thus granting retro-authorization in this case is warranted."

The respondent states, "The preauthorization Rule, 134.600, is quite clear. No payment is due for the dates not preauthorized."

A review of the submitted documentation finds that both parties agree that a preauthorization issue exists for the disputed dates of service. No documentation was submitted to support that concurrent preauthorization was obtained for February 10, 2013 through February 11, 2013. As a result, a preauthorization issue exists and reimbursement is not recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/10/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.